3 FQHC Guidelines Contents

3.1 Introduction

3.1.1 General Policy

This section covers all Medicaid covered services provided by Federally Qualified Health Centers (FQHC) as deemed appropriate by IDHW. Contents include the following:

- Encounters
- EPSDT Services
- Family Planning Services
- Electronic and paper claim billing
- Claims payment
- Electronic and paper claim billing

Note: Not all services are covered for CHIP-B participants. Prior to rendering or referring services for CHIP-B participants review the **CHIP-B Appendix**, **section B.1.5** for service limitations.

3.1.2 Advance Directives

An advance directive explains to a client his/her right to accept or refuse medical services, or to choose among available medical services. It also explains durable power of attorney and a living will.

Medicaid has directed that providers of home health care (including FQHCs, Rural Health Clinics and Indian Health Clinics) must provide all adult Medicaid clients advance directive information in an understandable format. If a client is unable to read the information, a relative or friend reads the information to him/her. If no one else is available, the provider must read the advance directive information to the client. If the provider is unable to abide by the medical desires of the client, the provider is required to assist the client in finding an alternative source of service.

3.1.3 Procedure Codes

Payment for medical screens is the all-inclusive rate for each client encounter. Any service included in the definition of an encounter will be billed and reimbursed with one of the following encounter codes:

T1015 physical or mental health visit

D2999 dental health visit

Refer to **Section 1.5**, Healthy Connections, for the Healthy Connections guidelines.

Claims for ambulatory services will be paid according to Medicaid's rules, regulations, and limitations for the specific service being rendered (optometric, pharmacy, etc.).

Check eligibility to see if the client is enrolled in Healthy Connections, Idaho's Primary Care Case Management (PCCM) model of managed care. If a client is enrolled, there are certain guidelines that must be followed to ensure reimbursement for providing Medicaid covered services.

Participants who have passed the month of their twenty-first (21st) birthday are eligible for an annual health risk assessment physical. Use diagnosis code V70.0 when billing these adult assessments.

Note: Medicaid Basic Plan Benefits participants are eligible for up to twenty-six (26) mental health services per year. Mental health encounters do not count toward the Medicaid Basic Plan Benefits participants twenty-six (26) services per year limit.

3.1.4 Non-covered Services

FQHC providers are advised to contact Medicaid prior to providing a new service to ensure they have met all criteria necessary to be qualified providers. Failure to notify Medicaid of a change in the ancillary services provided may result in the denial of a claim. FQHC encounters and ambulatory services, with the exception of home visits, must be provided on site.

The FQHC may obtain a separate physician clinic provider number to receive reimbursement for the physician hospital services at the rates on file with Medicaid. Physician services under contract to the FQHC must be specifically identified in the contract with the FQHC. The contracted services must be applicable to all FQHC clients.

3.1.5 Third Party Recovery

See **Section 2, General Billing Information**, Third Party Recovery, for information on Medicaid policy for billing all other third party resources before submitting claims to Medicaid.

3.2 Federally Qualified Health Center Policy

3.2.1 Overview

A Federally Qualified Health Center (FQHC) is a community health center, a migrant health center, a provider of care for the homeless, an outpatient health program, or a facility operated by an Indian tribal organization under the Indian Self-determination Act. Some clinics that provide ambulatory services may qualify even though they are not receiving grants under section 329, 330, or 340 of the Public Health Service Act.

All services provided by an FQHC must be provided according to the rules and guidelines set forth by Medicaid for each type of service. Medicaid will not pay for services that are the responsibility of other providers (such as; client care in a hospice, a nursing home or a hospital, etc.).

The FQHC may enter into the respective provider agreement observing all conditions applicable to all providers of the service after the Department of Health and Human Services and the Health Resources and Service Administration (HRSA) determine that the center meets the requirements to qualify for FQHC status.

3.2.2 Incidental Services

Services incidental to a billable encounter include:

- In-house radiology
- Physical therapy
- Occupational therapy
- Speech therapy
- Audiology services
- In-house laboratory services
- In-house nutritional education or dietary counseling and monitoring by a registered dietician
- Injectable medications
- Medical equipment and supplies

3.2.3 Encounters

An encounter is a face-to-face contact for the provision of medical, mental, or dental services between a client and a physician, physician assistant, nurse practitioner, clinical nurse specialist, clinical psychologist, clinical social worker, dentist, or dental hygienist.

Types of encounters include medical, mental health, and dental.

Each contact with a separate discipline of health professional (medical, mental, or dental) on the same day at the same location is considered a separate encounter.

All contacts with all practitioners within a disciplinary category (medical, mental, or dental) in the same day is considered one encounter.

Reimbursement for services is limited to three (3) separate encounters per patient per day, one for each discipline (medical, mental, or dental). An exception to this rule may be made if the encounter is caused by an illness or

injury that occurs later the same day as the first encounter, requires additional diagnosis or treatment, and is supported by documentation.

3.2.3.1 Place of Service

Enter **50 — Federally Qualified Health Center (FQHC)** code in the place of service field on the CMS-1500 claim form or in the appropriate field when billing electronically.

3.2.3.2 EPSDT Encounter

An Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) encounter should be billed as a medical encounter using procedure code **T1015**. Report with diagnosis ICD-9 code **V20.1** or **V20.2** to show that the encounter is a well baby or child examination and to satisfy federal reporting requirements. Refer to **Section 3.3** for more information on EPSDT services.

3.2.3.3 Dental Encounter

An encounter is a face-to-face contact for the provision of dental services between a client and a dentist or dental hygienist. The dental encounter code **D2999** should be billed with the diagnosis code **V72.2.** Dental services are limited for Medicaid clients. For information about services that are considered a benefit of the dental program, see the *Idaho Medicaid Provider Handbook*, Dental Guidelines.

http://www.healthandwelfare.idaho.gov/portal/alias_Rainbow/lang_en-US/tabID_3438/DesktopDefault.aspx

3.2.3.4 Other Ambulatory Services

If the FQHC wishes to provide other ambulatory services that are not part of the encounter, the provider must obtain a separate Idaho Medicaid provider number to receive payment for these services.

3.2.4 Laboratory Services

Laboratory tests performed by an FQHC are included in the encounter rate and cannot be billed to Medicaid. If an outside lab, not the clinic, performs a laboratory service, that lab must bill Medicaid directly.

3.3 EPSDT Services

3.3.1 Overview

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is designed to provide periodic screening of Medicaid eligible children for early detection of medical and developmental problems.

All EPSDT services are based on guidelines established by the Centers for Medicare and Medicaid Services (CMS).

See **Section 1.5.5.4** for the complete EPSDT Screening and Immunization Schedule.

3.3.2 Medical Screen Eligibility

All Medicaid eligible children ages birth through the last day of the month of their twenty-first (21) birthday are eligible for EPSDT screens. Parents periodically receive an informational letter reminding them the child is due to have an EPSDT screen.

The screen must include the appropriate laboratory tests for that periodicity schedule. The schedule is provided in Section 1.6, *General Provider and Client Information, EPSDT.*

Use diagnosis code **V20.1** — Other Healthy Infant/Child, or **V20.2** — Routine Infant or Child Health Check for all EPSDT screening claims.

3.3.2.1 History

History includes a comprehensive health and developmental history (including assessment of both physical and mental health development).

3.3.2.2 Physical Exam

This is a comprehensive unclothed physical examination, including visual inspection of mouth and teeth.

3.3.2.3 Laboratory

Federal mandate requires a screening for lead poisoning as a required component of an EPSDT screen. Current CMS policy requires a screening blood lead test for all Medicaid-eligible children at 12 and 24-months of age. In addition, children over the age of 24 months, up to 72 months of age, should receive a screening blood lead test if there is no record of a previous test.

3.3.2.4 Health Education

Health education includes anticipatory guidance.

3.3.3 Payment

Payment for EPSDT screens is the same as the rate for each all inclusive client encounter. Report encounter code **T1015** with one of the following modifiers to indicate the service is part of an EPSDT screening:

3.3.4 EPSDT Modifiers

Modifier	Modifier Description
EP	Service provided as part of Medicaid EPSDT program.
U6	Patient is referred to another provider.
25	*(Description change only):* Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service.

3.4 Family Planning Services

3.4.1 Overview

All claims for services or supplies that are provided as part of a family planning visit must include the **FP** (Family Planning) modifier with encounter code T1015.

Additionally, any family planning encounters should include one of the diagnoses listed in the table below as the **primary** diagnosis.

Diagnosis Code	Description
V25.01	Prescription of oral contraceptive
V25.02	Initiation of other contraceptive measure (fitting of diaphragm, prescription of foams, creams, other agents)
V25.09	Family planning advice (Other)
V25.1	Insertion of intrauterine contraceptive device
V25.2	Sterilization (admission)
V25.40	Contraceptive surveillance, unspecified
V25.41	Contraceptive pill surveillance
V25.42	Intrauterine device (checking, reinsertion, or removal of device) surveillance
V25.43	Implantable subdermal contraceptive surveillance
V25.49	Surveillance of other contraceptive method
V25.5	Insertion of implantable subdermal contraceptive
V25.8	Other specified contraceptive management (post-vasectomy sperm count)
V25.9	Unspecified contraceptive management

3.5 Claim Billing

3.5.1 Which Claim Form to Use

Claims that do not require attachments may be billed electronically using PES software (provided by EDS at no cost) or other HIPAA compliant vendor software.

To submit electronic claims, use the HIPAA-compliant 837 transaction.

To submit claims on paper, use original red CMS-1500 claim forms.

All claims must be received within one year of the date of service.

3.5.2 Electronic Claims

For PES software billing questions, consult the Idaho PES Handbook. Providers using vendor software or a clearinghouse should consult the user manual that comes with their software. Guidelines for electronic claims include the following:

See **Section 2** for more information on electronic billing.

Detail lines
Idaho Medicaid allows up to **50** detail lines for electronic HIPAA 837 Professional claims.

Referral number
A referral number is required on an electronic HIPAA 837 Professional claim when a client is referred by another provider. Use the referring provider's Medicaid provider number, unless the client is a Healthy Connections client. For Healthy Connections clients, enter the provider's Healthy Connections referral number.

Prior authorization (PA) numbers
Idaho Medicaid allows more than one prior authorization number per electronic HIPAA 837 Professional claim. PAs can be entered at the header or detail of the claim.

Modifiers
Up to **four** modifiers per detail are allowed on an electronic HIPAA 837 Professional claim.

Diagnosis codes
Idaho Medicaid allows up to **eight** diagnosis codes on an electronic HIPAA 837 Professional claim.

Electronic crossovers
Idaho Medicaid allows providers to submit electronic crossover claims for Professional services.

3.5.3 Guidelines for Paper Claim Forms

For paper claims, use only original red CMS-1500 claim forms to submit all claims to Idaho Medicaid. CMS-1500 claim forms are available from local form suppliers.

The CMS-1500 form can be used without changes for dates in the year 2000 and beyond. All dates must include the month, day, century, and year.

Example: July 4, 2004 is entered as 07/04/2004

3.5.3.1 How to Complete the Paper Claim Form

The following will speed processing of paper claims:

- Complete all required areas of the claim form.
- Print legibly using black ink or use a typewriter.
- When using a printer, make sure the form is lined up correctly so it prints evenly in the appropriate field.
- Keep claim form clean. Use correction tape to cover errors.
- Enter all dates using the month, day, century, and year (MM/DD/CCYY) format. Note that in field 24A (From and To Dates of Service) there are smaller spaces for entering the century and year. Refer to specific instructions for field 24A.
- A maximum of six line items per claim can be accepted. If the number of services performed exceeds six lines, prepare a new claim form and complete all the required elements. Total each claim separately.
- Be sure to sign the form in the correct field. Claims will be denied that are not signed unless EDS has a signature on file.
- Do not use staples or paperclips for attachments. Stack the attachments behind the claim.
- Do not fold the claim form(s). Mail flat in a large envelope (recommend 9 x 12).

3.5.3.2 Where to Mail the Paper Claim Form

Send completed claim forms to:

EDS
P.O. Box 23
Boise, ID 83707

3.5.3.3 Completing Specific Fields on the Paper Claim Form

Consult the Use column to determine if information in any particular field is required. Only fields that are required, required if applicable, or desired for billing the Idaho Medicaid program are shown on the following table. Claim processing will be interrupted when required information is not entered into a required field.

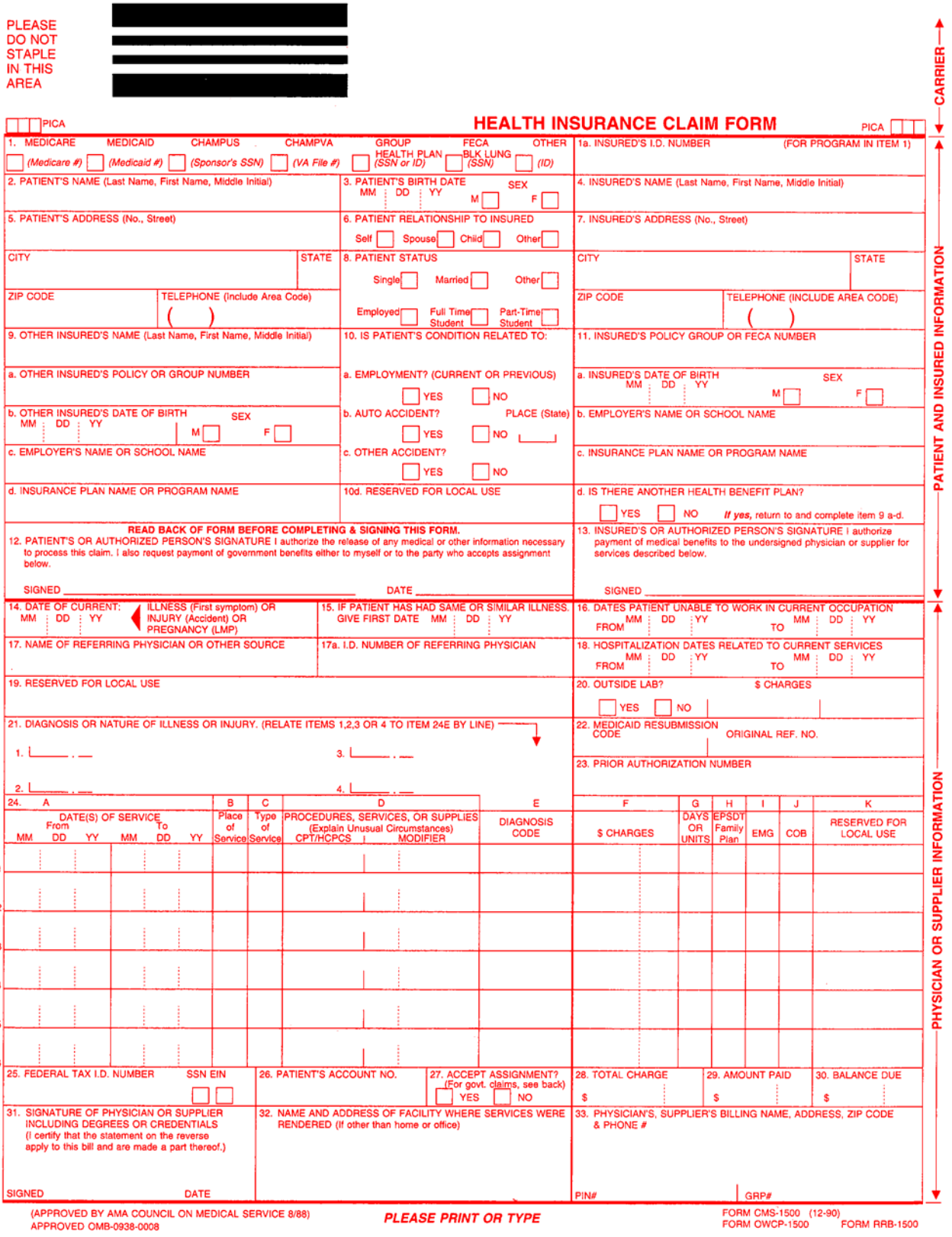
The following numbered items correspond to the CMS-1500 claim form.

Field	Field Name	Use	Directions
1a	Patient ID	Required	Enter the seven-digit client ID number exactly as it appears on the plastic client ID card.
2	Patient's Name	Required	Enter the client's name exactly as it appears on the Medicaid plastic ID card. Be sure to enter the last name first, followed by the first name and middle initial.
9a	Other Insured's Policy or Group Number	Required if applicable	Required if field 11d is marked YES. If the client is covered by another health insurance or medical resource, enter the policy number.

Field	Field Name	Use	Directions
9b	Other Insured's Date of Birth/Sex	Required if applicable	Required if field 11d is marked YES. If the client is covered by another health insurance or medical resource, enter the date of birth and sex.
9c	Employer's Name or School Name	Required if applicable	Required if field 11d is marked YES.
9d	Insurance Plan Name or Program Name	Required if applicable	Required if field 11d is marked YES. If the client is covered by another health insurance or medical resource, enter the plan name or program name.
10a	Is Condition Related to Employment?	Required	Indicate yes or no if this condition is related to the client's employment.
10b	Auto Accident?	Required	Indicate yes or no if this condition is related to an auto accident.
10c	Other Accident?	Required	Indicate yes or no if this condition is related to an accident.
11d	Is There Another Health Benefit Plan?	Required	Check yes or no if there is another health benefit plan. If yes, return to and complete items 9a-9d.
14	Date of Current: Illness, Injury or Pregnancy	Desired	Enter the date the illness or injury first occurred, or the date of the last menstrual period (LMP) for pregnancy.
15	If Patient Has Had Same or Similar Illness	Desired	If yes, give first date, include the century. For pregnancy, enter date of first prenatal visit.
17	Name of Referring Physician or Other Source	Required if applicable	Use this field when billing for a consultation or Healthy Connections client. Enter the referring physician's name.
17a	ID Number of Referring Physician	Required if applicable	Use this field when billing for a consultation or Healthy Connection client. Enter the referring physician's Medicaid provider number. For Healthy Connections clients, enter the provider's Healthy Connections referral number.
19	Reserved for Local Use	Required if applicable	If applicable, all requested comments for claim submission should be entered in this field. For example, enter injury information, including how, when, and where the injury occurred if another party is liable. This field can also be used to enter the ICN of previous claims to establish timely filing.
21 (1-4)	Diagnosis or Nature of Illness or Injury	Required	Enter the appropriate ICD-9-CM code (up to 4) for the primary diagnosis and, if applicable, second, third, and fourth diagnosis. Enter a brief description of the ICD-9-CM primary and, if applicable, second, third, and fourth diagnosis.
23	Prior Authorization Number	Required	Enter the prior authorization number from Medicaid, DHW, RMS, ACCESS, RMHA, EDS, Quality Improvement Organization (QIO), or MTU. Only one per claim allowed for paper.
24A	Date of Service — From/To	Required	Fill in the date(s) the service was provided, using the following format: MMDDCCYY (month, day, century, and year). **Example:** November 24, 2004 becomes 11242004 with no spaces and no slashes.
24B	Place of Service	Required	Enter the appropriate numeric code in the place of service box on the claim.

Field	Field Name	Use	Directions
24D 1	Procedure Code Number	Required	Enter the appropriate five-character CPT or HCPCS procedure code to identify the service provided.
24D 2	Modifier	Desired	If applicable, add the appropriate CPT or HCPCS modifier(s). Enter as many as three. Otherwise, leave this section blank.
24E	Diagnosis Code	Required	Use the number of the subfield (1-4) for the diagnosis code entered in field 21.
24F	Charges	Required	Enter your usual and customary fee for each line item or service. Do not include tax.
24G	Days or Units	Required	Enter the quantity or number of units of the service provided.
24H1	EPSDT (Health Check) Screen	Required if applicable	Not required unless applicable. If the services performed constitute an EPSDT program screen, refer to the instructions for EPSDT claims in the provider handbook.
24I	EMG	Desired	If the services performed are related to an emergency, mark this field with an **X**.
24K	Reserved for Local Use	Desired	When a group, agency, or clinic is the billing agency, enter the Idaho Medicaid provider number of the provider rendering the service in Field 24K and the group provider number in field 33.
28	Total Charge	Required	Add the charges for each line then enter the total amount.
29	Amount Paid	Required	Enter any amount paid by other liable parties or health insurance payment including Medicare. Attach documentation from an insurance company showing payment or denial to the claim including the explanation for the denial reason.
30	Balance Due	Required	Enter the total charges, less amount entered in amount paid field.
31	Signature and Date	Required	The provider or the provider's authorized agent must sign and date all claims. If the provider does not wish to sign or signature stamp each individual claim form, a statement of certification must be on file at EDS. See Section 1.1.4 for more information.
33	Provider Name and Address	Required	Enter your name and address exactly as it appears on your provider enrollment acceptance letter or RA. If you have had a change of address or ownership, please, immediately notify Provider Enrollment, in writing, so that the Provider Master File can be updated.
33	GRP — Provider Number	Required	Enter your nine-digit Medicaid provider number.

3.5.3.4 Sample Claim Form



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA (SSN) BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ . __ 3. ____ . __

2. ____ . __ 4. ____ . __

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statement on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)
APPROVED OMB-0938-0008

PLEASE PRINT OR TYPE

FORM CMS-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500